ing he went to bed in perfect health. He was scarcely asleep, when he awoke with a bound, seized with sudden suffocation. He jumped out of bed, traversed the chamber, and seated himself in a chair, with the death-rattle in his throat. A few instants afterwards he was dead. He died with white froth escaping from the nostrils and mouth.

But cases of this kind are not always fatal. Dr. De la Harpe treated on a former occasion a patient who had analogous crises ten or fifteen times without succumbing to them. He went to bed in good health. Towards midnight, or one o'clock in the morning, he was awakened by a sudden depression, accompanied by mortal anguish. In a few minutes the distress became extreme, and the aspect livid; death appeared imminent. The means employed always ended, however, by producing an improvement in the course of an hour. During all this time respiration consisted of an easy inspiration and a prolonged expiration, during which bubbling was produced throughout the chest, and seemed to fill the trachea. In a word, the patient, who was well a few minutes before, assumed the aspect of a moribund person suffocated by a frothy liquid, which filled the respiratory passages, and against which he struggled with all the energy of which his muscles were capable. The treatment consisted of hot dry applications and internal excitants, such as ether, ammonia, either pure or benzolated, or with aniseed in strong and repeated doses. But in the most violent crises these remedies did not suffice, and several times it was necessary to resort to a method which would seem to be of all means the least opportune—bleeding; nevertheless, it always succeeded, and immediately the crisis terminated by rapid eructations and forcible emissions of almost colourless urine. A crisis of this kind recurred twice or more frequently in the year. The patient was 65 years old when first taken. Towards the end of his life these crises became frequent and less vigorous, intelligence became obtuse, strength diminished, and finally occurred a slight degree of cachectic, and the patient succumbed with a great deal diminishing of strength. Dr. De la Harpe thinks that in this case also there was acute œdema of the lung; but, as an examination of the urine was not made in these patients, the albuminuric origin of the symptoms may be considered probable.—*London Medical Record*, Oct. 15, 1881.

Carcinoma of the Œsophagus with Perforation of the Left Auricle.

HINDENLANG reports in *Centralblatt f. d. Med. Wissenschaften*, No. 43, 1881, a case of carcinoma of the œsophagus which became adherent to the trachea and pericardium and caused necrotic softening of the left auricular and ventricular wall. The patient died from meningitis developed from emboli. Embolic infarctions were also found in the kidney, spleen, liver, and left parietal convolutions. Aphasia was also present. A somewhat similar case was published in the *Gazette Hebdomadaire*, in 1874, by M. Bertram.

Case of Rupture of the Septum Cordis.

Professor AXEL KEY and Dr. KJELLBERG relate in *Hygiea* for 1880 (*Nord. Med. Arkiv.*, Band xiii. Häft 2), the case of a man, aged 75, previously healthy, who, in July, 1880, was attacked with pain in the chest, eructations, general malaise, and pain in the left arm. He recovered so much as to be able to go out daily, but soon afterwards had an attack of weakness in the right arm. From this he had recovered somewhat a month later; but one day after dinner he was suddenly seized with pain in the region of the stomach, a sense of oppression in the chest, and pain in the back on the left side. In the evening, his hands and feet became cold. Over the apex of the heart, and through a great extent, a sharp systolic murmur was heard, replacing the first heart-sound, the heart's action was regular; the pulse could scarcely be felt in the right arm, and not at all in the left. He died during the night. At the necropsy, the heart was found to be somewhat hypertrophied. Nearly the whole of the septum ventriculorum was separated from its connection with the posterior muscular wall, and the posterior wall of the right ventricle was cleft for a very considerable extent. The rent began at the upper part of the left ventricle, about two-fifths of an inch from the aortic valves, and extended to the apex of the heart; for about four-fifths of an inch at the lower part it was complete, so that the two ventricles communicated. At the upper part, the rupture extended into the posterior wall of the right ventricle, separating into two layers. Nearly the whole surface of the rupture was covered with a thin and rather adherent layer of fibrin. The muscular tissue in general was flaccid, of a deep yellowish-gray colour. There were no essential changes in the valves or in the endocardium. The coronary arteries were in a state of advanced atheromatous degeneration, especially the right, the lumen of which, where it bent round the right border of the heart, was entirely filled with a firm adherent grayish-blue thrombus, rather more than an inch and a half long, and ending in a firm conical point. About two-fifths of an inch within, at the posterior part, the artery divided, and sent down in the ventricular furrow, behind the septum, a descending branch, which principally supplied blood to the ruptured part. No large ruptured vessel could be detected. Dr. Key says that the obstructing thrombus, in connection with the atheromatous degeneration, probably played the chief part in the production of the rupture. Probably, when the thrombus was formed, a rupture of a vessel with hemorrhage into the muscular tissue took place, producing distension of the muscular structure, which at last burst into the left ventricle, after which the rupture extended.—*London Med. Record*, Oct. 15, 1881.

Functional Murmur in the Pulmonary Artery.

From an interesting article on this subject, Mr. C. J. Nixon draws the following conclusions:—

1. That a functional murmur in the pulmonary artery, independent of anæmia or of direct pressure on the trunk or branches of the vessel, is not of infrequent occurrence.

2. That the conditions, given in order of frequency, in which it occurs are:—

(*a*) Acute articular rheumatism.

(*b*) Enteric fever.

(*c*) Fevers where there is great prostration and a tendency to profuse sweating.

(*d*) Bronchitis, or œdema of the upper lobe of one or both lungs.

(*e*) Nervous diseases, such as paraplegia from myelitis, tubercular meningitis, or in a debilitated state of the system, generally associated with hysteria or hypochondriasis.

(*f*) Cases, where, as from extreme serous distension of the cavity of the peritoneum, the diaphragm is subjected to great pressure upwards.

(*g*) Trivial affections, such as diarrhœa, dyspepsia, etc., especially where there exists a tendency to the paralytic thorax. Here it is usually met with in young and imperfectly-nourished adults, and occurs more frequently in females than in males.

3. That from the various conditions under which the murmur occurs it cannot be regarded as a sign of any special disease. It is in most cases of temporary duration, and it may occasionally be met with in a state of apparent health.

4. That its characters closely simulate those of a murmur of attrition—hence it has, in many instances, been erroneously regarded as a sign of localized pericarditis.—*Dublin Journ. of Med. Science*, Sept. 1881.